MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3,14 FilmG224 1-3-58 et

13171

CERTIFICATE OF DEATH

13169

Reg. Dist. No. 181

1. PLACE OF DEATH
a. COUNTY Harford. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre-de-Grace
c. LENGTH OF STAY IN 1b 2 hrs 15 min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen.
d. STREET ADDRESS 326 Law St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Charles Middle Leo Last Alder.

4. DATE OF DEATH Month 12 Day 18 Year 1957

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4 March 1903
9. AGE (In years last birthday) 54 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist
10b. KIND OF BUSINESS OR INDUSTRY Dentist
11. BIRTHPLACE (State or foreign country) Switzerland.
12. CITIZEN OF WHAT COUNTRY? Switzerland.

13. FATHER'S NAME Charles Alder
14. MOTHER'S MAIDEN NAME Louise Kunz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213 38 9111
17. INFORMANT Nina Alder (wife. Address 326 Law St. Abd, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatorenal Syndrome — INTERVAL BETWEEN ONSET AND DEATH 48 hr.
DUE TO
581.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Post-hepatitic cirrhosis — 3½ mo.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-30-57, 19 57 to 12-18-57, 19 57, that I last saw the deceased alive on 12-17-57, 19 57, and that death occurred at 9:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN Peter P. Rodman M.D.
ADDRESS (Street, city or town, state) 8 Law St Aberdeen, Md.
DATE SIGNED
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
22b. DATE THEREOF 12/21/1957
22c. NAME OF CEMETERY OR CREMATORY Greenmount
22d. LOCATION (City, town, or county) (State) Balto Maryland

23. FUNERAL DIRECTOR'S SIGNATURE John F. Loring
ADDRESS Aberdeen Md.
24a. REC'D BY REGISTRAR DATE Dec 22/57
24b. REGISTRAR'S SIGNATURE Nellie R. Perry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13172 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13170/85
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the [illegible] or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after [illegible].

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bridgeport — 75X-3
d. STREET ADDRESS: RD 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: ANNA — Middle: — Last: Allen

4. DATE OF DEATH: Month: December — Day: 22 — Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov 3, 1913

9. AGE (In years last birthday): 44 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): PENNA.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: NESTER —

14. MOTHER'S MAIDEN NAME: NO INFORMATION

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: No.

17. INFORMANT: MRS BARBARA HENSLEY — Address: CONSHOHOCKEN PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CRUSHING INJURY OF HEAD.
816X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident auto-auto type

20c. TIME OF INJURY: Hour 5 p. m. — Month, Day, Year: 12-22-1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt Route 40

20f. (City or town) Perryville (County) Cecil (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
Bel Air, Md. DATE SIGNED 12-22-57
EXAMINER'S NAME (Type): Gerald C. Palmer M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: DEC 28, 1957

22c. NAME OF CEMETERY OR CREMATORY: VALLEY FORGE MEMORIAL PARK

22d. LOCATION (City, town, or county): UPPER MERION TWP (State) PA.

23. FUNERAL DIRECTOR'S SIGNATURE: Pepper Funeral Home
ADDRESS: Donald M. Pepper Colton, Md.

24a. RECD BY REGISTRAR DATE: DEC 30 1957

24b. REGISTRAR'S SIGNATURE: Dr. A L Lewis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13200

CERTIFICATE OF DEATH

13171 18 Y

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fallston
c. LENGTH OF STAY IN 1b: Entire life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Fallston
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: David — Middle: H — Last: Amoss

4. DATE OF DEATH: Month: December — Day: 8 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept-30-1905

9. AGE (In years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Insurance

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel H. Amoss

14. MOTHER'S MAIDEN NAME: Dora Benson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service: No

16. SOCIAL SECURITY NO.: 278-14-2930

17. INFORMANT: Mrs. Rose Amoss — Address: Fallston Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Unknown
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c) Coronary Artery Disease — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 7, 1938, to December 8, 1957, that I last saw the deceased alive on July 16, 1955, and that death occurred at 9:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson, M.D. — ADDRESS (Street, city or town, state): Forest Hill, Maryland — DATE SIGNED: December 9, 1957

PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D.

Acting Deputy Medical Examiner Harford County

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec 11, 1957

22c. NAME OF CEMETERY OR CREMATORY: Friendship Methodist

22d. LOCATION (City, town, or county) (State): Fallston, Hd. Md

23. FUNERAL DIRECTOR'S SIGNATURE: W. H. Archer — ADDRESS: Benson Md

24a. REC'D BY REGISTRAR DATE: DEC 12 1957

24b. REGISTRAR'S SIGNATURE: Priscilla Forwood

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the reg... prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13173

CERTIFICATE OF DEATH

13172

Reg. Dist. No. 181

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 46 Smith Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 46 Smith Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Madora — Last: Becker

4. DATE OF DEATH: Month: 12 — Day: 19 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 23 - 1881

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Life

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): N. J.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Straughan

14. MOTHER'S MAIDEN NAME: Lavinia Robbins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Mrs Glen Bagwell 46 Smith St Aberdeen Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Haemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 hr.
204.1
DUE TO (b): Thrombocytopenia — 6 wk
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Acute myelogenous leukaemia — 6 wk

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-19-45 to 12-19-57, that I last saw the deceased alive on 12-19-57, and that death occurred at 8:00 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter P. Rodman, M.D. — ADDRESS (Street, city or town, state): 8 Law St. Aberdeen, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Peter P. Rodman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/22/1957

22c. NAME OF CEMETERY OR CREMATORY: Babers Cemetery

22d. LOCATION (City, town, or county) (State): Aberdeen Md

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Carring — ADDRESS: Aberdeen Md.

24c. REC'D BY REGISTRAR — DATE: Dec 22-57

24b. REGISTRAR'S SIGNATURE: Willie R. Perry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13174

CERTIFICATE OF DEATH

13173

Reg. Dist. No. 185

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABERDEEN
c. LENGTH OF STAY IN 1b: 18 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 43 HANOVER ST.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABERDEEN 31
d. STREET ADDRESS: 43 HANOVER ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HELEN — Middle: L. — Last: BODDY

4. DATE OF DEATH: Month: DECEMBER — Day: 14 — Year: 1957

5. SEX: FEMALE

6. COLOR OR RACE: COLORED

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/13/57

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours: 18 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Preston Boddy

14. MOTHER'S MAIDEN NAME: LILLIE REED

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs. Lillie Boddy - Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH:
762.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour o. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from DECEMBER 13 19 57 to DECEMBER 14, 19 57, that I last saw the deceased alive on DECEMBER 13, 19 57, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: George T. Stansbury M.D. — ADDRESS (Street, city or town, state): 569 Revolution St., Havre de Grace, Md. — DATE SIGNED: 12/14/57

PHYSICIAN'S NAME (Type): George T. Stansbury — Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-15-57

22c. NAME OF CEMETERY OR CREMATORY: Union Methodist Cem.

22d. LOCATION (City, town, or county) (State): Aberdeen, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Otis L. Bullock. Havre de Grace, Md.

24a. REC'D BY REGISTRAR — DATE: 12-15-57

24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2000284XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13175 CERTIFICATE OF DEATH

Reg. Dist. No. 13174, 85-

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 BEL AIR
d. STREET ADDRESS: RD #1 BOX 357
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EUGENE — Middle: H — Last: BOONE

4. DATE OF DEATH: Month: DECEMBER — Day: 21 — Year: 1957

5. SEX: MALE

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-8-1888

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Boone

14. MOTHER'S MAIDEN NAME: Leanah Conway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): 1911

16. SOCIAL SECURITY NO.: 236-14-9321

17. INFORMANT: Mrs. Martha M. Boone
Address: Rt#1 Box 357 Bel-Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure
DUE TO (b): Coronary Insufficiency
DUE TO (c): Hypertensive - Arteriosclerotic Heart disease

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1957, to Dec. 21, 1957, that I last saw the deceased alive on Dec. 21, 1957, and that death occurred at 5.20 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George T. Stansbury, M.D.
ADDRESS (Street, city or town, state): 569 Revolution St., Havre de Grace, Md.
DATE SIGNED: 12/21/57

PHYSICIAN'S NAME (Type): George T. Stansbury
Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-27-57
22c. NAME OF CEMETERY OR CREMATORY: Clark's Chapel Cemetery
22d. LOCATION (City, town, or county) (State): Harford County Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Otelia J. Bullock
ADDRESS: Havre de Grace Md.

24a. REC'D BY REGISTRAR DATE: 12-23-57

24b. REGISTRAR'S SIGNATURE: A. L. Peters M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13176

13175

Reg. Dist. No. 18-7

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air Rural
c. LENGTH OF STAY IN 1b: 18 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Bel Air Rural
d. STREET ADDRESS: 1 Churchville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Oscar; Middle: ; Last: Bowser

4. DATE OF DEATH: Month: Dec. Day: 25 Year: 1957

5. SEX: male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 9, 1882

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Trucking

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Richard Bowser

14. MOTHER'S MAIDEN NAME: Ellen Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Edith Bowser — Address: Bel Air R.D. #2 Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c): Hypertensive Arteriosclerotic Heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/20, 1954, to 12/25, 1957, that I last saw the deceased alive on 12/23, 1957, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: George T. Stansbury, M.D. — ADDRESS (Street, city or town, state): 569 Revolution St., Havre de Grace, Md. — DATE SIGNED: 12/27/57

PHYSICIAN'S NAME (Type): George T. Stansbury

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 28, 1957

22c. NAME OF CEMETERY OR CREMATORY: Hosanna

22d. LOCATION (City, town, or county) (State): Darlington, Harford, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard R. Mikrut Jr.

ADDRESS: Abingdon, Md.

24a. REC'D BY REGISTRAR DATE: DEC 31 1957

24b. REGISTRAR'S SIGNATURE: Priscilla Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13176

13177 **CERTIFICATE OF DEATH**

Reg. Dist. No. 18 1

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen
c. LENGTH OF STAY IN 1b —
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural #1 (Stephney)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Aberdeen.
d. STREET ADDRESS Rural #1 (Stephney)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Hoyd Middle Lost Brown
4. DATE OF DEATH Month 12 Day 19 Year 1957

5. SEX Male
6. COLOR OR RACE Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4/29/1955
9. AGE (In years last birthday) 2 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child
10b. KIND OF BUSINESS OR INDUSTRY Child.
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Mable Osborne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Address Morgan Reid Aberdeen #1 Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH
491X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 19, 1957, to Dec. 19, 1957, that I last saw the deceased alive on Dec. 17, 1957, and that death occurred at 6:00 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE George T. Stansbury, M.D. ADDRESS (Street, city or town, state) 569 Revolution St., Havre de Grace, Md. DATE SIGNED 12/21/57
PHYSICIAN'S NAME (Type) George T. Stansbury

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12/23/57
22c. NAME OF CEMETERY OR CREMATORY John Wesley Cemetery
22d. LOCATION (City, town, or county) (State) Abingdon, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE John G. Torrey ADDRESS Aberdeen Md.
24a. RECD BY REGISTRAR DATE Dec 23 57
24b. REGISTRAR'S SIGNATURE Nellie R Perry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13177

13201 **CERTIFICATE OF DEATH**

Reg. Dist. No. 181

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: US Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Chesapeake Gardens Aberdeen, Md.
d. STREET ADDRESS: 402-E Watervleit St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RICHARD Middle Last BURKE
4. DATE OF DEATH: Month December Day 2 Year 19 57
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11 September 53
9. AGE (In years last birthday): 4 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Frankfurt Germany
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Lester Burke
14. MOTHER'S MAIDEN NAME: Joan I Harris
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT: Father — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Concussion Severe — INTERVAL BETWEEN ONSET AND DEATH: 9 Hours
816X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): "ead injury, Laceration spleen, Contusion of left Lung
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in automobile, struck by truck
20c. TIME OF INJURY Hour a. m. 0955 Month, Day, Year 2 Dec 1957
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway Route 40
20f. (City or town) Aberdeen (County) Harford (State) Md.

21. I certify that I attended the deceased from 2 December, 1957, to 2 December, 1957, that I last saw the deceased alive on 2 December, 1957, and that death occurred at 1840p M, from the causes and on the date stated above.

ACTUAL SIGNATURE: V. G. Coseriu M.D. — ADDRESS (Street, city or town, state): US ARMY HOSPITAL ABERDEEN PROVING GROUND, Md. — DATE SIGNED: 3 December 1957

PHYSICIAN'S NAME (Type) V G COSERIU MAJOR MC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/6/57
22c. NAME OF CEMETERY OR CREMATORY: Post Cemetery
22d. LOCATION (City, town, or county) (State): Aberdeen Proving Ground, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John G Loring — ADDRESS: Aberdeen, Md.
24a. REG'D BY REGISTRAR DATE: Dec. 6/57
24b. REGISTRAR'S SIGNATURE: Nellie K Perry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the reg[illegible] prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13178

13178 CERTIFICATE OF DEATH

Reg. Dist. No. 151

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Aberdeen.
d. STREET ADDRESS: RT #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Melvin Middle: Thomas Last: Burkins

4. DATE OF DEATH: Month: 12 Day: 2 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3 Sept. 1900

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer.

10b. KIND OF BUSINESS OR INDUSTRY: Truck driver Oil Company

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Mollie Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-07-7311

17. INFORMANT: Elsie Burkins — Address: R#1 Aberdeen Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Myocardial Infarction	4 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Arteriosclerotic Cardio Vascular disease	5 yrs
DUE TO (c)		

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 15, 1957, to 12/2, 1957, that I last saw the deceased alive on Nov 2, 1957, and that death occurred at 4 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Dudley Phillips M.D. — ADDRESS (Street, city or town, state): Darlington Md — DATE SIGNED: 12/4/57

PHYSICIAN'S NAME (Type): Dudley Phillips — Darlington, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	12/7/57	Bel Air Memorial Gar.	Bel Air, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Fanning — ADDRESS: Aberdeen, Md.

24c. REC'D BY REGISTRAR DATE: Dec 6/57

24b. REGISTRAR'S SIGNATURE: Nellie R Perry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13202 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13179

Reg. Dist. No. 182

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norrisville
c. LENGTH OF STAY IN 1b —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Church Road, Highway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norrisville x 2
d. STREET ADDRESS /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Gladys Middle: H. Last: Clark

4. DATE OF DEATH Month: December Day: 14 Year: 1957

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH July 1, 1920

9. AGE (In years last birthday) 37 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY HOME

11. BIRTHPLACE (State or foreign country) NORRISVILLE E

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME HOWARD PRESTON HOLSHART

14. MOTHER'S MAIDEN NAME OLIVE E WAILES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-16-6615

17. INFORMANT Thomas A Clarke Address 110 LINHIGH AVE BALTO. 6 MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound, comminuted

DUE TO (b) fracture skull

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

816X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident auto-object type

20c. TIME OF INJURY Hour 4 a.m. p.m. Month, Day, Year 12-14 57

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Church Road

20f. (City or town) Norrisville (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Gerald C Palmer M.D. CHIEF MEDICAL EXAMINER ☐ Bel Air, Md DATE SIGNED

EXAMINER'S NAME (Type) Gerald C Palmer M.D. ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ 12-15-57

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 12/17/57

22c. NAME OF CEMETERY OR CREMATORY NORRISVILLE

22d. LOCATION (City, town, or county) NORRISVILLE (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hunt ADDRESS Jarrettsville Md

24a. REC'D BY REGISTRAR DATE 12-19-57

24b. REGISTRAR'S SIGNATURE Burrill Toward

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13180

13180 CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 40 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:
STATE: MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 216 N. Union Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anne Middle: E. Last: Davis

4. DATE OF DEATH: Month: 12 Day: 16 Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 12, 1888

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Dublin Harford Co Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm. S. Daugherty

14. MOTHER'S MAIDEN NAME: Georgianna Cantler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. F. C. Kohler Address: 216 N. Union Ave. Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary Edema	1 day
DUE TO (b)	Pulmonary Infarction	3 days
DUE TO (c)	Coronary Thrombosis & Embolism	10 days

420.1

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/13, 19 57, to 12/16, 19 57, that I last saw the deceased alive on 12/16, 19 57, and that death occurred at 10:10 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank Wolbert M.D. M.D. ADDRESS (Street, city or town, state): 200 North Union Ave Havre de Grace Md DATE SIGNED: 12/18/57

PHYSICIAN'S NAME (Type): FRANK WOLBERT MD Havre de Grace Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/19/57

22c. NAME OF CEMETERY OR CREMATORY: Angel Hill

22d. LOCATION (City, town, or county) (State): Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Funeralus Wm. ADDRESS: Havre de Grace Md.

24a. REC'D BY REGISTRAR DATE: 12-19-57

24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the re[illegible] prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13181

CERTIFICATE OF DEATH

Reg. Dist. No. 13181 185

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de Grace, Rt #1
c. LENGTH OF STAY IN 1b: 23 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland. b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de Grace Rt #1 - X0
d. STREET ADDRESS: Robin Hood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Gordon Middle L Last Davis
4. DATE OF DEATH: Month December Day 25 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/24/1931
9. AGE (In years last birthday): 26 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK DRIVER
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Millard Davis
14. MOTHER'S MAIDEN NAME: Martha (Roark)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT (Address): Millard Davis, Robin Hood Road, Harford Co. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 3 months
592X
DUE TO (b): Chronic Nephritis — 3 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 10, 1957, to Dec. 25, 1957, that I last saw the deceased alive on Dec. 25, 1957, and that death occurred at 12:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gunther D. Hirsch M.D. — ADDRESS (Street, city or town, state): 421 CONGRESS AVE. HAVRE DE GRACE, MD. — DATE SIGNED

PHYSICIAN'S NAME (Type): GUNTHER D. HIRSCH — HAVRE de GRACE Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/28/57
22c. NAME OF CEMETERY OR CREMATORY: Stephen Perry Cem.
22d. LOCATION (City, town or county) (State): Horse Cove N.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Perry Funeral Home Havre de Grace Md — ADDRESS
24a. REC'D BY REGISTRAR DATE: 12-26-57
24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the re... prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13203 CERTIFICATE OF DEATH

13182 184 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Bel Air
c. LENGTH OF STAY IN 1b: 7 mo

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Bel Air Rural

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

d. STREET ADDRESS: 1 ~~Churchill~~ Calvary

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Karren Middle Fay Last Epperson

4. DATE OF DEATH: Month December Day 8 Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr. 28, 1957

9. AGE (In years last birthday): 7 mo

IF UNDER 1 YEAR: Months 7 Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert L. Epperson

14. MOTHER'S MAIDEN NAME: Mollie M. Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Albert L. Epperson Address: New Castle Delaware

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH

490x

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 12-8-57

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-7, 1957 to 12-8, 1957 that I last saw the deceased alive on 12-7, 1957, and that death occurred at 10A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gerald C Palmer M.D. ADDRESS (Street, city or town, state): Bel Air, Md. DATE SIGNED: 12-8-57

PHYSICIAN'S NAME (Type): Gerald C Palmer MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 11, 1957

22c. NAME OF CEMETERY OR CREMATORY: Epperson Family Cemetery

22d. LOCATION (City, town, or county) (State): Bluefield, Tazewell, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard R. Miller Jr. ADDRESS: Abingdon, Maryland.

24a. REC'D BY REGISTRAR DATE: DEC 13 1957

24b. REGISTRAR'S SIGNATURE: Priscilla Harwood

9 V V V V V X V V

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13204 CERTIFICATE OF DEATH

Reg. Dist. No. 13183

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fallston
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Friendship Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Fallston
d. STREET ADDRESS: Friendship Rd.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Maurice Middle C. Last Fitch
4. DATE OF DEATH: Month Dec, Day 30, Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Dec, 17, 1890
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dispatcher
10b. KIND OF BUSINESS OR INDUSTRY: Sand & Gravel Co.
11. BIRTHPLACE (State or foreign country): Balto. Co. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Robert Fitch
14. MOTHER'S MAIDEN NAME: Susan Grammer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-28-4034
17. INFORMANT: Mrs. Helen P. Fitch — Address: Friendship Rd. Fallston Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 min.
DUE TO (b): Coronary Sclerotic Heart Dis — 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): H20.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchial Asthma a. Ch. Alcoholism
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/17, 19[illegible] to 12/30, 19[illegible], that I last saw the deceased alive on 12/30, 1957, and that death occurred at 5:45 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE, M.D.: Clifford F. Hudson — ADDRESS (Street, city or town, state): Fork Md. — DATE SIGNED
PHYSICIAN'S NAME (Type): CLIFFORD F. HUDSON FORK, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 2, 1958
22c. NAME OF CEMETERY OR CREMATORY: Zion Evan. Lutheran
22d. LOCATION (City, town, or county) (State): Stemmers Run Balto. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Tawaha Funeral Home — ADDRESS: 7401 Belair Rd.
24a. REC'D BY REGISTRAR DATE: JAN 3 1958
24b. REGISTRAR'S SIGNATURE: Priscilla Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13205

CERTIFICATE OF DEATH

13184

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D. #1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen (Rural)
d. STREET ADDRESS: R.D. #1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Lena — Middle: Matilda — Last: Ford

4. DATE OF DEATH: Month: December — Day: 6 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 27 Sept. 1895

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Nursing

11. BIRTHPLACE (State or foreign country): Perryman, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George S. Ford

14. MOTHER'S MAIDEN NAME: Sarah Matilda Day

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: *** ***

17. INFORMANT: E. Lawrence Ford — Address: Perryman, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Failure	(Terminal)
DUE TO (b)	Marasmus	3 wk
DUE TO (c)	Reticular cell sarcoma, retroperitoneal	2 1/2 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

200.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to 12-6-, 1957, that I last saw the deceased alive on Dec 5-, 1957, and that death occurred at 6:50 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William V. Rodman, M.D. — ADDRESS (Street, city or town, state): 8 Law Street — DATE SIGNED

PHYSICIAN'S NAME (Type): Peter P. Rodman M.D. — Aberdeen, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/8/57

22c. NAME OF CEMETERY OR CREMATORY: Spesutia Cemetery

22d. LOCATION (City, town, or county) (State): Perryman, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Fearing — ADDRESS: Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: Dec. 7-57

24b. REGISTRAR'S SIGNATURE: Willie R. Perry

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13206 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 13185

Reg. Dist. No. 182

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
c. LENGTH OF STAY IN 1b: 2 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ Street
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First George Middle F. Last Frank
4. DATE OF DEATH: Month December Day 17 Year 19 57
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 28, 1957
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months 2 Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Robert Tenaglia
14. MOTHER'S MAIDEN NAME: Sally Franke
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mrs. Louise Lindberg, 1107 Cavendish Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia
491X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congenital heart disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
Bel Airm Md.
DATE SIGNED: Dec. 16 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 19, 1957
22c. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
22d. LOCATION (City, town, or county) (State): Colgate, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ullrich Funeral Home 2112 Dundalk Ave.
24a. RECD BY REGISTRAR DATE: DEC 17 1957
24b. REGISTRAR'S SIGNATURE: Priscilla Forwood
EJ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13182

CERTIFICATE OF DEATH

13186

Reg. Dist. No. 185

1. PLACE OF DEATH
a. COUNTY: Harford County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Haven de Grace
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Forest Hill
d. STREET ADDRESS: Box 378 Hoopes Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Winnie; Middle: L.; Last: Goins (Goines)

4. DATE OF DEATH: Month: December; Day: 28; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jany 27/1895

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: ✓

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: John Dudley Reedy

14. MOTHER'S MAIDEN NAME: Mattie Mc Grody

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Harrison P. Goins — Address: Box 378 Hoopes Rd. Forest Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Posterior Coronary thrombosis with Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks.
DUE TO (b): Hypertensive and Arteriosclerotic
DUE TO (c): Cardiovascular disease — ?

443x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 260 Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ ✓

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 9th, 19 57, to Dec 28th, 19 57, that I last saw the deceased alive on Dec 28th, 19 57, and that death occurred at 7:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward C Foo M.D. — ADDRESS (Street, city or town, state): 211 N. Union Ave. — DATE SIGNED: 12/28/57

PHYSICIAN'S NAME (Type): Edward C. Foo, M.D. Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec 30/57

22c. NAME OF CEMETERY OR CREMATORY: Mt Zion Methodist

22d. LOCATION (City, town, or county) (State): Fountain Green Harford Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster — ADDRESS: Bel Air, Md.

24a. REC'D BY REGISTRAR DATE: JAN 3 1958

24b. REGISTRAR'S SIGNATURE: Dr A. L. Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the re... prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13207

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13187 Reg. Dist. No. 181

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aber-deen
c. LENGTH OF STAY IN 1b 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USA Hosp.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun 07X1.2
d. STREET ADDRESS RD 1 e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First Evelyn Middle Rutter Last Green
4. DATE OF DEATH Month December Day 9 Year 1957
5. SEX F
6. COLOR OR RACE W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH 8 Jan 1907
9. AGE (In years last birthday) 50 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting Clerk
10b. KIND OF BUSINESS OR INDUSTRY Civil Service
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George P. Rutter
14. MOTHER'S MAIDEN NAME Margery Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-22-0373
17. INFORMANT Address Charles H. Green, Rising Sun, Md. RD 1.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH —
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and find that death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE Gerald C Palmer M.D.
EXAMINER'S NAME (Type) Gerald C Palmer MD
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Bel Air Md
DATE SIGNED 12-9-57

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12-12-1957
22c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery
22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural

23. FUNERAL DIRECTOR'S SIGNATURE Kell a, Patterson & Long
ADDRESS Perryville, Md.
24a. REC'D BY REGISTRAR DATE Dec 11-57
24b. REGISTRAR'S SIGNATURE Nellie R Perry

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the record prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13208

13188

CERTIFICATE OF DEATH

Reg. Dist. No. 1842

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kalmia
c. LENGTH OF STAY IN 1b: 2 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Jarrettsville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Lucretia — Middle A — Last Harkins

4. DATE OF DEATH: Month December — Day 20 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 12, 1873

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR OR UNDER 24 HRS. — Months — Days — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Harkins

14. MOTHER'S MAIDEN NAME: Sarah Mechem

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Mrs. Helen Harkins, Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure, terminating — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Chronic Cardio-vascular Disease — ?
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 55, to December 20, 1957, that I last saw the deceased alive on December 19, 1957, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city or town, state): Forest Hill, Maryland — DATE SIGNED: December 20, 1957

PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 22, 1957

22c. NAME OF CEMETERY OR CREMATORY: Brick Baptist Church

22d. LOCATION (City, town, or county) (State): Jarrettsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Foster Bel Air Md. — ADDRESS

24a. REC'D BY REGISTRAR DATE: 12-22-57

24b. REGISTRAR'S SIGNATURE: Priscilla Sowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13189

13209 # CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH

COUNTY: HARFORD — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL JOPPA

LENGTH OF STAY (in this place): 5 YRS.

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: MD. COUNTY: HARFORD

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL JOPPA.

STREET ADDRESS (If rural give location): JOPPA RD #2

3. NAME OF DECEASED (Type or Print): (First) Ozella (Middle) Marie (Last) Heaps

4. DATE OF DEATH: (Month) 12 (Day) 28 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F.	W.		1-29-1885	72 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	OWN HOME	HARFORD Co., MD.	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM WALSH RICHARDSON	ELIZABETH RODGERS WILGIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
	—	Ruth H. Zeigler Joppa Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 month.

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Essential Hypertension — 30 yrs

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10 ..., 1947..., to 12-28..., 1957..., that I last saw the deceased alive on 12-27..., 1957..., and that death occurred at 7 A...M, from the causes and on the date stated above.

SIGNATURE Ted O Hodous M.D. **ADDRESS** (Street, city, town, state) Edgewood Md **DATE SIGNED** 12-28-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	12-31-1957	NORRISVILLE METH.	NORRISVILLE, HARFORD Co., MD.

24. REC'D BY REGISTRAR DATE 12-28-57	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
	Priscilla Fawood	Kenneth W Chukum, Stewartstown Pa

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13183 CERTIFICATE OF DEATH

Reg. Dist. No. 13190, 9

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Belair
c. LENGTH OF STAY IN 1b: 6 Weeks

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Hall 03x2.2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Conv. Home

d. STREET ADDRESS: Box 140 Rt. 1 Joppa, Md.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Adam Middle: J. Last: Heil

4. DATE OF DEATH: Month: Dec. Day: 2, Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 16, 1866

9. AGE (In years last birthday): 91 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brick Layer-Retired

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?: US.A.

13. FATHER'S NAME: John Heil

14. MOTHER'S MAIDEN NAME: Cecelia Deigelman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mrs. William Plummer Rt. 1 Box 140 Joppa, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION (Embolus incident to Auricular fibrillation) — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs ?

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Chr. Hypertensive cardio-vascular disease — ?

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cirrhosis of liver

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 10, 19 57, to Dec. 2, 19 57, that I last saw the deceased alive on Dec. 1st, 19 57, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson, M.D. ADDRESS (Street, city or town, state): Forest Hill, Md. DATE SIGNED: 12-2-57

PHYSICIAN'S NAME (Type): WILLARD P. HUDSON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-5-1957

22c. NAME OF CEMETERY OR CREMATORY: Parkwood

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lassahn Funeral Home ADDRESS: 7401 Belair Rd

24a. REC'D BY REGISTRAR DATE: DEC 9 1957

24b. REGISTRAR'S SIGNATURE: Priscilla Fawcett

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13191

13184 **CERTIFICATE OF DEATH**

Reg. Dist. No. 181

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: #3 Rogers Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Aberdeen
d. STREET ADDRESS: #3 Rogers Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stella — Middle: Blackwell — Last: Johnson

4. DATE OF DEATH: Month: 12 — Day: 27 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/24/1878

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Theoarde Blackwell

14. MOTHER'S MAIDEN NAME: Elizabeth Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: C.H. Johnson — Address: #3 Rogers St Aberdeen Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Renal Uremia
DUE TO
442x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/2 19 44 to 12-24 19 57 that I last saw the deceased alive on 12/24 19 57, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. L. Lewis M.D. — ADDRESS (Street, city or town, state): Aberdeen Md — DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/30/57
22c. NAME OF CEMETERY OR CREMATORY: North East Cemetery
22d. LOCATION (City, town, or county) (State): North East, Cecil Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Fanning — ADDRESS: Aberdeen Md.

24a. REC'D BY REGISTRAR DATE: Dec 30-57
24b. REGISTRAR'S SIGNATURE: Nellie R Perry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13185

CERTIFICATE OF DEATH

13192

Reg. Dist. No. 185

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 1 hr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
d. STREET ADDRESS: Race St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Dolores Middle Last Jones

4. DATE OF DEATH: Month 12 Day 18 Year 1957.

5. SEX: Female
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-3-1956
9. AGE (In years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months 11 Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Robert H. Jones
14. MOTHER'S MAIDEN NAME: Addie E. Griffin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Addie E. Jones, Race St, Port Deposit, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
056.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Pertussis — Duke-
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov-12, 1957, to Dec 17, 1957, that I last saw the deceased alive on Dec 17-, 1957, and that death occurred at 1.30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Clarence I Benson M.D.
ADDRESS (Street, city or town, state): Port Deposit
DATE SIGNED: 12/19/57

PHYSICIAN'S NAME (Type): Clarence I. Benson, M.D. Port Deposit Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-21-1957
22c. NAME OF CEMETERY OR CREMATORY: Jones Memorial Cemetery
22d. LOCATION (City, town, or county) (State): Port Deposit, Md. Rural

23. FUNERAL DIRECTOR'S SIGNATURE: Vera A. Patterson & Son
ADDRESS: Perryville, Md.
24a. REC'D BY REGISTRAR DATE: 12-21-57
24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13186

CERTIFICATE OF DEATH

13193

Reg. Dist. No. 185-

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: LIFETIME
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: NONE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE 24
d. STREET ADDRESS: 840 OTSEGO ST. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First CLARA Middle HAYES Last KENNEDY

4. DATE OF DEATH: Month 12 Day 29 Year 1957

5. SEX: 7

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 3/20/1880

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): HAVRE de GRACE

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRANKLIN OWENS

14. MOTHER'S MAIDEN NAME: MARY M. ANDERSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: UNK

17. INFORMANT: FRANKLIN KENNEDY, Address: 840 OTSEGO ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion. — INTERVAL BETWEEN ONSET AND DEATH
592 x
DUE TO
(b): Chronic Myocarditis —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Chronic Nephritis - Diabetes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 260 x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 16, 19 57 to 12-29, 19 57 that I last saw the deceased alive on Dec 24, 19 57, and that death occurred at 7 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. L. Lewis M.D. ADDRESS (Street, city or town, state): Havre de Grace Md DATE SIGNED: 12/31/57

PHYSICIAN'S NAME (Type): A. L. Lewis — Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 1/1/58

22c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL

22d. LOCATION (City, town, or county) (State): HAVRE de GRACE Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Pennington & Son, Havre de Grace Md

24a. REC'D BY REGISTRAR DATE: 12-31-57

24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13194

13210

CERTIFICATE OF DEATH

Reg. Dist. No. 182

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Bel Air

LENGTH OF STAY (In this place): 32 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Wakefield-Forest Drive

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Md. COUNTY: Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Bel Air

STREET ADDRESS (If rural give location): Wakefield-Forest Drive

3. NAME OF DECEASED (Type or Print): (First) Dorothea (Middle) Bilz (Last) Kunkel

4. DATE OF DEATH: (Month) Dec (Day) 28 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
F	White	MARRIED	August 22, 1887	70 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Housework	Baltimore Md	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Bilz	Barbara Baier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		—	Mr. John N. Kunkel Wakefield Forest Drive Bel Air, R.D., Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
443 IMMEDIATE CAUSE	(A) CONVULSION & CARDIO RESP FAILURE	5 MINUTES
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	(B) CEREBRAVASCULAR ACCIDENT	10 MINUTES.
DUE TO	(C) HYPERTENSIVE CARDIOVASCULAR DISEASE	10 YRS.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. STROKE 3 YRS AGO.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
—		

22. I hereby certify that I attended the deceased from ..., 1947, to 28 DEC, 1957, that I last saw the deceased alive on 20 DEC, 1957, and that death occurred at 10:45 P.M., from the causes and on the date stated above.

SIGNATURE: H P Sidwell M.D. ADDRESS (Street, city, town, state): 401 Franklin St. Bel Air, Md. DATE SIGNED: 30 Dec 57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Dec. 31, 1957	Holy Redeemer	Baltimore, Md.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE 12-30-57	Priscilla Forwood	Joseph William Foster	West Broadway Bel Air, Maryland

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The b[illegible] copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13195

13211 # CERTIFICATE OF DEATH

Reg. Dist. No. 18V

1. PLACE OF DEATH

COUNTY Harford Co. — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lalleton

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Fallston

STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED (Type or Print) (First) Leo (Middle) LEO BADIN LATHROUM (Last) Lathroum

4. DATE OF DEATH (Month) Dec. (Day) 24 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W	Married	1897	60 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Druggist	self	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Leo Jefferson Lathroum	Mary Odie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no	-	-	Mrs. Mary C. Lathroum Fallston Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A) Terminal Arrhythmia or Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 15 min.

ANTECEDENT CAUSE(S) DUE TO (B) Chronic Congestive Heart Failure — 2 yrs.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerosis & Valvular Insufficiency and Cardiomegaly

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1957, to Dec., 1957, that I last saw the deceased alive on Dec. 20, 1957, and that death occurred at 1:55 P.M., from the causes and on the date stated above.

SIGNATURE William A. Tyo M.D. — **ADDRESS** (Street, city, town, state) Kingsville Md — **DATE SIGNED** 12-24-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12/27/57	Druid Ridge Cem	Balto.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
12/27/57	Russell Forwood	WIEDEFELD & SON-Greenmount & 22nd

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13196

13187 **CERTIFICATE OF DEATH**

Reg. Dist. No. 185-

1. PLACE OF DEATH
a. COUNTY: Harford
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 78 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace 24
d. STREET ADDRESS: 114 N. Union Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rhea Middle: Leona Last: Lutkiser

4. DATE OF DEATH: Month: 12 Day: 13 Year: 57 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/13/1879

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Havre de Grace

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James W. Foster

14. MOTHER'S MAIDEN NAME: Laura Jane Wright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Not (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: R. H. Lutkiser Address: 114 N. Union Ave, Havre de Grace Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Carcinosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Ascending Colon Liver and Ovaries
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

199.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-14 19 57, to Dec 23 19 57, that I last saw the deceased alive on Dec 23 19 57, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. L. Lewis M.D. ADDRESS (Street, city or town, state): Havre de Grace Md DATE SIGNED: 12-26-57

PHYSICIAN'S NAME (Type): A. L. Lewis Havre de Grace, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/26/57

22c. NAME OF CEMETERY OR CREMATORY: Angel Hill

22d. LOCATION (City, town, or county) (State): Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Cunningham & Son, Havre de Grace Md ADDRESS

24a. REC'D BY REGISTRAR DATE: 12-26-57

24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13212 13197

Reg. Dist. No. 180

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Long Bar

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Abingdon
d. STREET ADDRESS Long Bar
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Frank Middle C. Last Lord
4. DATE OF DEATH Month December Day 24 Year 1957

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH Aug. 5, 1887
9. AGE (In years last birthday) 70 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Munition Handler
10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.,
11. BIRTHPLACE (State or foreign country) Washington, D.C.,
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 705-14-0968
17. INFORMANT Frederick J. Mover Address Abingdon, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald C Palmer M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
Bel Air, Md. DATE SIGNED 12-24-57
EXAMINER'S NAME (Type) Gerald C Palmer (M.D.)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Dec. 26, 1957
22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran
22d. LOCATION (City, town, or county) (State) Joppa, Harford, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McCormick Jr. ADDRESS Abingdon Maryland.
24a. REC'D BY REGISTRAR DATE Dec. 26, 1957
24b. REGISTRAR'S SIGNATURE Nora G. Moore

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13188

CERTIFICATE OF DEATH

13198 41

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: after 4 mths.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 277 Victory Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: Residepce before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Bel Air.
d. STREET ADDRESS: 277 Victory Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: Joseph — Last: Loughran

4. DATE OF DEATH: Month: 12 — Day: 19 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/16/1906

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance Supt.

10b. KIND OF BUSINESS OR INDUSTRY: Harford Schools.

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Frank Loughran

14. MOTHER'S MAIDEN NAME: Mary Ellen Merrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): War II

16. SOCIAL SECURITY NO.:

17. INFORMANT: wife — Address: 277 Victory Lane Bel Air Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mins
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Coronary Atherosclerosis — 1 yr
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug, 1955, to Dec, 1957, that I last saw the deceased alive on Dec 17, 1957, and that death occurred at 2:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Ralph Horky M.D. — ADDRESS (Street, city or town, state): Churchville Md — DATE SIGNED: Dec 19

PHYSICIAN'S NAME (Type): J. Ralph Horky MD Churchville Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/23/57

22c. NAME OF CEMETERY OR CREMATORY: St Mary's

22d. LOCATION (City, town, or county) (State): Hanover Township, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: John J. Garvey — ADDRESS: Aberdeen Md.

24a. REC'D BY REGISTRAR DATE: 12/20/57

24b. REGISTRAR'S SIGNATURE: Nellie R Perry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13189

CERTIFICATE OF DEATH

13199

Reg. Dist. No. 182

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 1 Hour
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Forest Hill
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Herman Wilson — Middle: — Last: Minnick

4. DATE OF DEATH: Month: December — Day: 4 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: September 18, 1905

9. AGE (In years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Aberdeen Proving Ground

10b. KIND OF BUSINESS OR INDUSTRY: Government Employee

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Roy A. Minnick

14. MOTHER'S MAIDEN NAME: Bessie Wilgis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-22-0961

17. INFORMANT Address: Robert Minnick, Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO

(c): Hypertensive Cardio-vascular Disease — 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 2, 1937, to December 4, 1957, that I last saw the deceased alive on December 4, 1957, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city or town, state): Forest Hill, Md. — DATE SIGNED: December 6, 1957

PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): DEC. 7 1957

22b. DATE THEREOF: BURIAL

22c. NAME OF CEMETERY OR CREMATORY: DEER CREEK Methodist Cem.

22d. LOCATION (City, town, or county) (State): Harford Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster — ADDRESS: W. Broadway, Bel Air, Md.

24a. REC'D BY REGISTRAR DATE: 12-6-57

24b. REGISTRAR'S SIGNATURE: Priscilla Lowood

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the reg[illegible] prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13190

13190 CERTIFICATE OF DEATH

Reg. Dist. No. 13200 / 8 1

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rural #2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x1 Aberdeen
d. STREET ADDRESS: Rural #2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Annie — Middle: Everist — Last: Moore

4. DATE OF DEATH: Month: Dec. — Day: 10th — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 4/6/1874

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Geo. S. Everist

14. MOTHER'S MAIDEN NAME: Eliza Ann Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs Geo R. Jones Aberdeen #2 Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma & Lung — INTERVAL BETWEEN ONSET AND DEATH:
156.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-3 19 57 to 12/10 19 57, that I last saw the deceased alive on 12-10 19 57, and that death occurred at 8 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A.L. Lewis M.D. — ADDRESS (Street, city or town, state): Havre de Grace, Md. — DATE SIGNED: 12/11/57

PHYSICIAN'S NAME (Type): A.L. Lewis M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/12/57

22c. NAME OF CEMETERY OR CREMATORY: Smiths Chapel

22d. LOCATION (City, town, or county) (State): Aberdeen #2 Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Garring — ADDRESS: Aberdeen Md.

24a. REC'D BY REGISTRAR DATE: 12-11-57

24b. REGISTRAR'S SIGNATURE: Nellie R Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13191 13201

CERTIFICATE OF DEATH

Reg. Dist. No. 18S

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: HARFORD — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MD b. COUNTY: HARFORD
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE — c. LENGTH OF STAY IN 1b: 50 YRS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE 24
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 710 MARKET, ST.	d. STREET ADDRESS: 710 MARKET, S.T. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
EVALEEN		MOORE	DECEMBER	18	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
FEMALE	WHITE		AUG. 9 1865	92 yrs.	— / —	— / —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE	HOME	N. J.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JAMES ALE	HANNAH WADDINGTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
—	—	MRS. JENNIE F. HIPPLE, HAVRE DE GRACE, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 3 months

450.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) ARTERIOSLEROSIS - CONGESTIVE H. D.

DUE TO

(c) OLD AGE

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that I attended the deceased from Oct. 19 57, to DEC 15, 1957, that I last saw the deceased alive on Nov. 15, 1957, and that death occurred at 11:15 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gunther D. Hirsch M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 12-20-57

PHYSICIAN'S NAME (Type): GUNTHER D. HIRSCH — 421 CONGRESS AVE. HAVRE DE GRACE, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	12-20-1957	ANGEL HILL	HAVRE DE GRACE MD

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
R. Madison Mitchell, HAVRE DE GRACE MD	12-20-57	A. L. Lewis M.D.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The burial permit copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

13213

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13202

Reg. Dist. No. 151

1. PLACE OF DEATH

COUNTY HARFORD — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAVRE DE GRACE

LENGTH OF STAY (in this place) 3 WEEKS

HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MD COUNTY HARFORD

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO RURAL HAVRE DE GRACE

STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED (Type or Print) (First) LILLIE (Middle) MAY (Last) MORRIS

4. DATE OF DEATH (Month) DEC (Day) 12 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE	WIDOWED	MAY 7, 1894	63 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE	HOME	MD	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Thomas CURRY	SUSAN A. MOBERRY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
		WILLIAM R MORRIS

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE (A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 4 months

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1957, to DEC. 12, 1957, that I last saw the deceased alive on Nov 30, 1957, and that death occurred at 5 P. M, from the causes and on the date stated above.

SIGNATURE Gwyn H. Workman M.D. ADDRESS (Street, city, town, state) Havre de Grace Md DATE SIGNED 12/14/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	12-15-1957	Rock Run Cem.	HARFORD Co. MD

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS
Dec. 17 57	Nellie R. Perry	R. Madison Mitchell, Havre de Grace MD

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13192 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13203

Reg. Dist. No. 181

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in-hospital, give street address) Harford Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen
d. STREET ADDRESS 1 Baldwin Manor APT B-6-4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Nancy Middle Mae Last Morris
4. DATE OF DEATH Month December Day 7 Year 1957

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH 5 Sept. 1939
9. AGE (In years last birthday) 18 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator
10b. KIND OF BUSINESS OR INDUSTRY Bata Shoe Co.
11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Howard Morris
14. MOTHER'S MAIDEN NAME Amy Deckman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-36-9898
17. INFORMANT Howard Morris, Address Apt. B-6-4 Baldwin Manor, Aberdeen Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) G.S.W. R chest — INTERVAL BETWEEN ONSET AND DEATH

919.6

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Man dropped pistol from belt + it fired

20c. TIME OF INJURY Hour 9 a.m. p.m. Month, Day, Year Dec 7 1957
20d. INJURY OCCURRED While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Shamrock Diner
20f. (City or town) Aberdeen (County) Harford (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald C Palmer M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
Baltimore, Md
DATE SIGNED 12-8-57

EXAMINER'S NAME (Type) Gerald C Palmer MD

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12/11/57
22c. NAME OF CEMETERY OR CREMATORY Southern Methodist
22d. LOCATION (City, town, or county) Dublin, (State) Maryland

23. FUNERAL DIRECTOR'S SIGNATURE John L. Leering
ADDRESS Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE Dec. 9-57
24b. REGISTRAR'S SIGNATURE Nellie R. Penn
Dr. A. L. Leering

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after

VS. A15ME
8M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13193 13204

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: Entire life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Bel Air
d. STREET ADDRESS: Bond Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: C — Last: Orsborn

4. DATE OF DEATH: Month: December — Day: 18 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: February 7, 1874

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: House Work

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Enos Rice

14. MOTHER'S MAIDEN NAME: Alice Chancey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Hannah Toney, Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 Months
592x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic Glomerular Nephritis with Hypertension — 10 Years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1947, 19____, to December 18, 1957, that I last saw the deceased alive on December 18, 1957, and that death occurred at 10:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city or town, state): Forest Hill, Maryland — DATE SIGNED: DECEMBER 19, '57

PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 21, 1957

22c. NAME OF CEMETERY OR CREMATORY: Hendon's Hill

22d. LOCATION (City, town, or county) (State): Bel Air R.D. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster — ADDRESS: Bel Air, Maryland

24a. REC'D BY REGISTRAR DATE: 12-19-57

24b. REGISTRAR'S SIGNATURE: Priscilla Sawood

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13214 **CERTIFICATE OF DEATH** 13205

Reg. Dist. No. 180

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Reckord Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Joppa
d. STREET ADDRESS: Record Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle A. Last RUPPERT

4. DATE OF DEATH: Month December Day 18 Year 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 12, 1890

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: At Home.

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Kolb

14. MOTHER'S MAIDEN NAME: Margaret Eisenreich.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No / No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Howard Ruppert — Address: Same.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 Mos.

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart Disease — 7 yrs.

DUE TO (c): with decompensation.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/5, 1957, to 12/18, 1957, that I last saw the deceased alive on 12/18, 1957, and that death occurred at 11:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clifford F. Hudson M.D. — ADDRESS (Street, city or town, state): Fork, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): CLIFFORD F. HUDSON — FORK, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-21-57.

22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer CEM.

22d. LOCATION (City, town, or county) (State): 4430 BELAIR RD. BALTO., MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. Feiler — ADDRESS: 901 S. CONKLING ST. BALTO., 24, MD.

24a. REC'D BY REGISTRAR DATE: DEC 23 1957

24b. REGISTRAR'S SIGNATURE: Norma Moore

EJ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the r... prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13215 **CERTIFICATE OF DEATH**

13206

Reg. Dist. No. 182

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xo Street R.F.D.
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First James Middle Isaac Last Slade
4. DATE OF DEATH Month Dec Day 29 — Year 1957
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Nov 22nd 1880
9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR Months Days 23 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY General Farm
11. BIRTHPLACE (State or foreign country) Federal Hill
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Wm Ralph Slade
14. MOTHER'S MAIDEN NAME Mary Susan Fletcher
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. —
17. INFORMANT David S. Slade Address Street Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Atherosclerosis, generalized
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gastro-enteritis & Colitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar, 1957, to 20 Dec, 1957, that I last saw the deceased alive on 19 Dec, 1957, and that death occurred at 1 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Thos. A.E. Moseley Jr M.D. ADDRESS (Street, city or town, state) Jarrettsville, Md. DATE SIGNED

PHYSICIAN'S NAME (Type) Thos. A.E. Moseley, Jr. Jarrettsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Dec 22-57
22c. NAME OF CEMETERY OR CREMATORY Jarrettsville
22d. LOCATION (City, town, or county) (State) Jarrettsville Md

23. FUNERAL DIRECTOR'S SIGNATURE Mervin G. Lee ADDRESS Jarrettsville
24a. REC'D BY REGISTRAR DATE 12-23-57
24b. REGISTRAR'S SIGNATURE Priscilla Forward

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13194 **CERTIFICATE OF DEATH**

Reg. Dist. No. 13207 185

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre-de-Grace
c. LENGTH OF STAY IN 1b 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md — b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Havre-de-Grace
d. STREET ADDRESS 607 Bourbon St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Myrtle Middle Viola Last Smith
4. DATE OF DEATH Month 12 Day 27 Year 1957
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10/4/1908
9. AGE (In years last birthday) 49 yrs.
IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-Wife
10b. KIND OF BUSINESS OR INDUSTRY Same
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Arthur A Preston
14. MOTHER'S MAIDEN NAME Cecil A Rice
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Howard Smith. Address 607 Bourbon St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive G.I. Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
540.0
DUE TO (b) Erosion of pancreatico-duodenal vein
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Acute ulceration.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 14, 1957 to Dec 27 1957 that I last saw the deceased alive on Dec. 27, 1957, and that death occurred at 8:45 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE Wm K Brindle M.D. ADDRESS (Street, city or town, state) Havre de Grace DATE SIGNED 12-28-57

PHYSICIAN'S NAME (Type) Wm K. Brindle. Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 12/30/1957
22c. NAME OF CEMETERY OR CREMATORY Angel Hill
22d. LOCATION (City, town, or county) (State) Havre de Grace, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pennington & Son, Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE 12-31-57
24b. REGISTRAR'S SIGNATURE G. L. Kenny M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13195

CERTIFICATE OF DEATH

13208

Reg. Dist. No. 183-

Item#3. Film Ch[illegible]

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: [illegible]

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace

c. LENGTH OF STAY IN 1b: 17hrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City [illegible] 3V01-4

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

d. STREET ADDRESS: 317 Macon Street [illegible]

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Katherine Baby Ann Middle: Girl Last: Spellman

4. DATE OF DEATH: Month: 12 Day: 27 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ (Never Born)

8. DATE OF BIRTH: 12-26-57

9. AGE (In years last birthday): yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: 17 Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newborn.

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Martin Spellman JR.

14. MOTHER'S MAIDEN NAME: Emily Bernadyne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Premature baby - Pulmonary Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO
(b):
DUE TO
(c):

762.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-26, 1957, to 12-27, 1957, that I last saw the deceased alive on 12-27, 1957, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. H. Richards M.D. ADDRESS (Street, city or town, state): P.O. Box 1, Port de Posit, Md. DATE SIGNED: 12-28-57

PHYSICIAN'S NAME (Type): G. H. Richards JR. Port de Posit Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/28/57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Erin

22d. LOCATION (City, town, or county) (State): Havre de Grace, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas Lee Sr. ADDRESS: Havre de Grace. Md

24a. REC'D BY REGISTRAR DATE: 12-28-57

24b. REGISTRAR'S SIGNATURE: G. H. Lewis Md.

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death: Page 4 [illegible] signed by the attending physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages [illegible] should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/SS

2071202 XV2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13209

13196 CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 401-A Watervliet Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Aberdeen
d. STREET ADDRESS: 401-A Watervliet Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Susannah; Middle Dunsworth; Last Taylor

4. DATE OF DEATH: Month December; Day 12; Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 21 Jan. 1876

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Boring

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: -- -- --

17. INFORMANT: Olin O. Taylor
Address: Aberdeen, Md. 401-A Watervliet Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
420.0
DUE TO (b): Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 10, 1957, to Dec 12, 1957, that I last saw the deceased alive on Dec 12, 1957, and that death occurred at 2:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Andre Weiss M.D. — ADDRESS (Street, city or town, state): 17 North Phila. Blvd — DATE SIGNED: 12/13/57

PHYSICIAN'S NAME (Type): ANDRE WEISS MD — Aberdeen Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 12/14/57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Hannibal Missouri

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Farring —
ADDRESS: Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: Dec. 14 57
24b. REGISTRAR'S SIGNATURE: Willie R. Perry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13197

13210

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 17 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
d. STREET ADDRESS: 214 S. Washington
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET — Middle Vinson — Last TROXE

4. DATE OF DEATH: Month DECEMBER — Day 19 — Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/7/1926

9. AGE (In years last birthday): 31 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HSWf.

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John D. Vinson

14. MOTHER'S MAIDEN NAME: Willard BAKER Logan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Dr. J. L. Troxe Jr. — Address: 214 S. Washington Ave Havre de Grace Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Lymphocytic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 4 months
204.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) —
DUE TO
(c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19 —

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) (County) (State) —

21. I certify that I attended the deceased from Sept. 16th., 19 57 to Dec 19th., 19 57 that I last saw the deceased alive on Dec 19th., 19 57 and that death occurred at 4:25 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward Lee M.D. — ADDRESS (Street, city or town, state): 211 N. Union Ave. — DATE SIGNED: 12/19/57

PHYSICIAN'S NAME (Type): Edward C. Lee, M.D. Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 12/21/57 — 22c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Memorial — 22d. LOCATION (City, town, or county) (State): Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Thompson Fun. Home — ADDRESS: Havre de Grace, Md

24a. REC'D BY REGISTRAR DATE: 12-21-57 — 24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13216 **CERTIFICATE OF DEATH** 13211

Reg. Dist. No. 181

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: U.S. Army Hospital, APG, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Florida — b. COUNTY: Walton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DeFuniak Springs 48 x 3
d. STREET ADDRESS: 304 S. 2nd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KENNETH — Middle DEAN — Last WHITTON

4. DATE OF DEATH: Month December — Day 7 — Year 19 57

5. SEX: M

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 23 October 1955

9. AGE (In years last birthday): 2 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Florida

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Charlie M. Whitton

14. MOTHER'S MAIDEN NAME: Helen Annett Ruryk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: -- -- --

17. INFORMANT: Father
Address: 17 Fern Street, Edgewood, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bacterial meningitis, pneumococcic — INTERVAL BETWEEN ONSET AND DEATH
340.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 December, 19 57, to 7 December, 19 57, that I last saw the deceased alive on 7 December, 19 57, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William M. Michener M.D. — ADDRESS (Street, city or town, state): USAH, APG, Md. — DATE SIGNED: 9 December 1957

PHYSICIAN'S NAME (Type): WILLIAM M. MICHENER, Capt, MC

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 12/10/57
22c. NAME OF CEMETERY OR CREMATORY: Magnolia Cemetery
22d. LOCATION (City, town, or county) (State): DeFuniak Springs, Fla.

23. FUNERAL DIRECTOR'S SIGNATURE: John D. Terring — ADDRESS: Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: Dec. 10/57

24b. REGISTRAR'S SIGNATURE: Nellie R. Perry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

RECEIV

DEC 12 19

BUREAU

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bo[illegible] copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within [illegible] **hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13198

CERTIFICATE OF DEATH

13212

Reg. Dist. No. 185

1. PLACE OF DEATH

COUNTY HARFORD — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE

LENGTH OF STAY (in this place) 6 MOS.

HOSPITAL OR INSTITUTION OR STREET ADDRESS 200 So. UNION, AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MD. COUNTY HARFORD

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE

STREET ADDRESS (If rural give location) 200 So. UNION AVE.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) CHARLES MAURICE WOLBERT MD.

4. DATE OF DEATH (Month) (Day) (Year) DEC. 3 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	MARRIED	JUNE 11, 1898	59 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MEDICAL DOCTOR	RETIRED	OHIO	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
FRANK MAURICE WOLBERT	CAROLYN C. BURLINGAM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
YES	WORLD WAR #II		DR. FRANK WOLBERT HAVRE DE GRACE MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

463X IMMEDIATE CAUSE (A) Acute Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 15 min

ANTECEDENT CAUSE(S) DUE TO (B) Chronic Phlebothrombosis R. leg — 13 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Malignancy of large intestine — 1 yr

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 July, 1957, to 3 Dec, 1957, that I last saw the deceased alive on Dec. 3, 1957, and that death occurred at 330 A.M, from the causes and on the date stated above.

SIGNATURE Wallace H. Sadowsky M.D. ADDRESS (Street, city, town, state) 600 S. Union Av. Havre de Grace, Md. DATE SIGNED 12/3/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	DEC. 5, 1957	ANGEL HILL CEM.	HAVRE DE GRACE MD.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
12-5-57	C. L. Lewis M.D.	J. T. Madison Mitchell	Havre de Grace, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 FilmG22) 1-7-58 et

13217 13213

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH
a. COUNTY USAH APG, HARFORD — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY HARFORD

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ABERDEEN PROVING GROUNDS

c. LENGTH OF STAY IN 1b
1 DAY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ABERDEEN MARYLAND

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
USAH APG, MD.

d. STREET ADDRESS
18 LIBERTY ST.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	WANE	NMI	WONG		DEC	28	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WAU Mong.		9 DEC 56 (56)	1 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
N/A	N/A	ABERDEEN MARYLAND	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WOTIM WONG	DOMIANA BAROY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
N/A	N/A	N/A	Wotim Wong	18 Liberty St. Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DEHYDRATION, ACUTE — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

571.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) VOMITING AND DIARRHEA — 3 DAYS

DUE TO (c) BRONCHOPNEUMONIA — 2 DAYS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 27 Dec, 1957, to 28 Dec, 1957, that I last saw the deceased alive on 28 Dec, 1957, and that death occurred at 1 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Charles C. Weise M.D. — ADDRESS (Street, city or town, state) 303 D Augusta St. Aberdeen, Md. — DATE SIGNED 28 Dec 57

PHYSICIAN'S NAME (Type) CHARLES C. WEISE, MD

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Removal	12/31/57	Nat. Mem. Cem. of Pacific Honolulu, Hawaii	

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
John G. Tarring	Aberdeen, Md.	Dec 31-57	Willie R. Perry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13199 13214

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG223 12-26-57 et

Reg. Dist. No. 185

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Deleware
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Neark
d. STREET ADDRESS: 12 Park Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

46X-3

3. NAME OF DECEASED (Type or print): First: William T. Middle: Wright Last:
4. DATE OF DEATH: Month: December Day: 15 Year: 1957

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH:
9. AGE (In years last birthday): Approx. 35 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ATTENDANT
10b. KIND OF BUSINESS OR INDUSTRY: Service Station
11. BIRTHPLACE (State or foreign country): DELAWARE
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Thomas Wright
14. MOTHER'S MAIDEN NAME: Adele Walstrum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Subdural Hematoma — INTERVAL BETWEEN ONSET AND DEATH: 5 days
825X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 12-13-57 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, street, public bldg., etc.): Cherry Hill
20f. (City or town): Cherry Hill (County): Cecil (State): Md.
U.S. 40

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C. Palmer M.D.
Bel Air, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-16-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-19-1957
22c. NAME OF CEMETERY OR CREMATORY: Silverbrook
22d. LOCATION (City, town, or county) (State): Wilmington Delaware

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Nicholas J. Corleto Wilm., Dela
24a. REC'D BY REGISTRAR DATE: DEC 19 1957
24b. REGISTRAR'S SIGNATURE: Dr. A. L. Lewis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57